

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 17, 18, 19, 20, 21, &amp; 24, 2011</p> <p>Facility number: 000250 Provider number: 155359 AIM number: 100289980</p> <p>Survey team: Sue Brooker RD TC Rick Blain RN Sheryl Roth RN Angie Strass RN</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 4 Medicaid: 38 Other: 4 Total: 46</p> <p>Stage 2 sample: 36</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p>Please accept this Plan of Correction as our credible allegations of compliance. The Plan of Correction does not constitute or agreement by the provider of the truth of facts or conclusions set forth in this statement of deficiencies. The Plan of corrections is prepared solely because it is required by Federal and State Law. Riverbend Health Care allegation of compliance date is 11/23/2011.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Quality review completed 10/30/11 Cathy Emswiller RN						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0272 SS=D	<p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to accurately assess 2 of 3 residents (Resident #53 and #51) who met the criteria for Oral/Dental Status and accurately code the information on the Minimum Data Set [MDS] Assessment. The facility also failed to provide accurate assessment and documentation of the hearing status</p>			F0272	<p>F272 SS: D Comprehensive assessmentsIt is the policy of Riverbend Health Care Center to comply with regulatory requirement comprehensive assessments.1. a. Res #53 re-assessed for dental and oral care related to ill-fitting dentures. Care plan revised to reflect oral status and interventions. b. Res #37 has been re-assessed by MDS to include hearing deficit</p>		11/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>for 1 of 36 residents (Resident #37) reviewed for assessments on the MDS.</p> <p>Findings include:</p> <p>1. Resident #53's record was reviewed on 10/19/11 at 10:10 a.m. The record indicated Resident #53's diagnoses included, but were not limited to, high blood pressure, anemia, bipolar disorder, bilateral hearing loss, renal failure and current history of smoking.</p> <p>The care plan for self care deficit, dated 10/29/10, with a goal date of 12/25/11, indicated "assist with oral care" twice daily. The care plan did not indicate the resident had an upper denture and lower partial. Nor did the care plan list the resident preferred not to wear his denture/partial.</p> <p>The annual MDS, dated 9/19/11, indicated Resident #53 did not have any broken or loosely fitting full or partial denture [chipped, cracked, unclean, or loose]. The MDS also indicated no obvious or likely cavity or broken natural teeth or difficulty with chewing.</p> <p>The October 2011 Medication Record for Resident #53, indicated</p>				<p>and care plan will be revised to include residents preference not to wear adaptive hearing aides and interventions will include staff anticipate adjusting speaking tone during communication. c. Resident #51 re-assessed by MDS to include accurate oral assessment.2. Facility MDS coordinator will conduct a review of residents most current or recent MDS assessment and compare to residents actual oral and hearing assessment to assure care plan reflects residents current oral and hearing status.3. DON or designee re-educate MDS coordinator per RAI guidelines related to accurate assessments oral and hearing.DON or designee will QA all new admissions comprehensive MDS assessments sections include oral/dental and hearing x 3 months and compare to residents actual status and assure care plan reflects accurate assessments.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations ,until 100% compliance is achieved times 3 months.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>"mechanical soft diet d/t [due to] chewing difficulty."</p> <p>Dental visits for adjustments to dentures in the clinical record were dated 10/12/11, 8/9/11, 6/15/11, 6/1/11, 5/9/11, 5/4/11 and 2/1/11 [multiple teeth extractions]. A dental visit note on 10/12/11 indicated he didn't feel Resident #53 was motivated to succeed with his dentures.</p> <p>Resident #53 was observed sitting up in a wheelchair in his room on 10/24/11 at 1:25 p.m. The resident was observed to have missing lower teeth and remaining teeth which were yellow in color with plaque build up and food debris between the lower front teeth.</p> <p>The MDS nurse was interviewed on 10/24/11 at 1:10 p.m. During the interview, the MDS nurse indicated she was unable to find any documentation of an oral assessment being completed for the 9/19/11 MDS. At 2:00 p.m., on 10/24/11, the MDS nurse indicated she notified nursing ahead of time on what assessments were due. A clinical review should then have been completed by nursing which would have included an inspection of the resident's lips, teeth,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>dentures, mucous membranes, tongue, mouth/facial pain, etc.</p> <p>Resident #53 was interviewed on 10/24/11 at 1:25 p.m. The resident indicated he had upper dentures and a lower partial which did not fit correctly so he chose not to wear them. He further indicated he keeps them in a drawer in his room.</p> <p>2. Resident #37's record was reviewed on 10/17/11 at 2:30 p.m. The record indicated Resident #37's diagnoses included, but were not limited to, congestive heart failure, coronary artery disease, depression, dementia, and osteoarthritis.</p> <p>A hearing evaluation, dated 10/11/10, indicated Resident #37 had moderate to severe hearing loss. The evaluation further indicated Resident #37 had tried hearing aids but they didn't work for her.</p> <p>The annual MDS, dated 9/2/11 for Resident #37 listed the resident as having adequate hearing [no difficulty in normal conversation, social interaction, listening to TV].</p> <p>The care plan for Alteration in Communication, dated 7/6/09 with a</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>goal date of 11/29/11, indicated Resident #37 had an alteration in communication due to hearing problem deficit.</p> <p>Resident #37 was interviewed on 10/17/11 at 12:18 p.m. During the interview, the resident was unable to understand spoken speech unless the speaker got close to the resident and raised the volume of speech.</p> <p>An interview was conducted with CNA #4 on 10/21/11 at 1:40 p.m. During the interview, CNA #4 indicated Resident #37 was hard of hearing and used to wear hearing aids.</p> <p>3. The record for Resident #51 was reviewed on 10/20/11 at 12:30 PM. Diagnoses include, but were not limited to, weakness/confusion, HTN (hypertension), BPH (benign prostatic hypertrophy), Bipolar disorder, moderate dementia, chronic kidney disease, severe anxiety, and depression.</p> <p>During an interview with Resident #51 on 10/17/2011 at 3:15 P.M., the resident had his own natural teeth,</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>with several upper teeth broken or missing.</p> <p>An admission data collection form, dated 5/27/11, indicated Resident #51 had his natural teeth, and some were broken and/or chipped.</p> <p>The admission MDS, dated 6/06/2011, indicated Resident #51 had no natural teeth and no tooth fragments.</p> <p>A significant change MDS, dated, 8/09/2011, indicated Resident #51 had no natural teeth and no tooth fragments.</p> <p>The 2010 version of the Resident Assessment Instrument (RAI), provided by the facility MDS nurse on 10/21/11 at 2:00 P.M., indicated "check...no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth." The RAI further indicated "check...obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen."</p> <p>The facility MDS nurse was interviewed on 10/21/2011 at 11:00 am. During the interview, the MDS nurse indicated the MDS dated 6/06/2011 and the MDS dated</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>8/09/2011 were both coded incorrectly for Resident #51's dental status as he did have his own teeth and some broken teeth.</p> <p>3.1-31(d)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review and interview, the facility failed to update the fall care plan with the implementation of the dycem (non-slip material) in the wheelchair for 1 of 5 residents (Resident #37) who met the criteria for accidents in the Stage 2 Sample of 26.</p> <p>Findings include:</p> <p>On 10/20/11 at 3:02 p.m., Resident #37 was observed in her room, no dycem was noted in the wheelchair.</p> <p>On 10/24/11 at 9:10 a.m., Resident #37 was observed in bed. The resident's wheelchair was sitting</p>			F0279	<p>F 279 SS: D Develop Comprehensive care plansIt is the policy of Riverbend Health Care Center to comply with regulatory requirement development of compressive care plans.1. Res #37's Care Plan revised to include the intervention of dycum (non-slip material).2. The facility has conducted a review of residents who have fallen two or more times in the past 6 months from w/c to insure care planned interventions are in place and effective.3. Licensed staff will be re-educated on facility policy and procedure related to fall risk and implementation of care-planned interventions are in place and effective.The facility interdisciplinary team (IDT) will review residents who have fallen</p>		11/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>beside the bed with a pressure reducing cushion in the seat along with the hoyer sling pad. No dycem was observed.</p> <p>A review of the clinical record for Resident #37, on 10/17/11 at 2:30 p.m., indicated a telephone order, dated 1/15/11, for dycem to be placed on Resident #37's wheelchair seat.</p> <p>A condition change form, dated 1/15/11, indicated Resident #37 had an assisted fall from her wheelchair in the dining room. The form indicated Resident #37 slipped off the wheelchair seat and was assisted to the floor by staff.</p> <p>Nurse's Notes, dated 1/15/11 at 11:30 a.m., indicated Resident #37 was assisted to the floor after the resident slid from her wheelchair. The note further indicated the resident's hoyer pad was removed and dycem was placed in the chair.</p> <p>A facility care plan Potential for Falls, dated 3/24/11 with a goal date of 11/29/11, did not include the intervention of dycem in the wheelchair.</p> <p>CNA #4 was interviewed on 10/24/11 at 9:10 a.m. During the interview,</p>				<p>in daily clinical meeting to ensure appropriate/effective interventions are implemented and care plan revised to reflect new interventions. Residents who have fallen referred to therapy post fall. DON or designee will conduct random visual observation of 2 residents daily x two weeks then weekly x 1 month then monthly to assure interventions for fall risk are in place as care planned.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations as indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>CNA #4 indicated Resident #37 used to use dycem (non-slip material) but not anymore. She further indicated none was in the wheelchair currently, just a cushion.</p> <p>The current policy for Fall Risk Reduction &amp; Management, dated 8/10, was provided by the Director of Nursing on 10/21/11 at 10:00 a.m. The policy listed the following: "...The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence...Revise the care plan to indicate changes in interventions as indicated...Modify and document goals and interventions as indicated...Communicate changes to the care giving team...."</p> <p>3.1-35(a) 3.1-35(b)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0282 SS=G	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow a physician's order for pain medication for 1 of 3 residents (Resident #65) who met the criteria for pain. This resulted in Resident #65 experiencing intense pain and requesting pain medication frequently. The facility also failed to toilet as indicated in the care plan 1 of 5 residents (Resident #23) who met the criteria for toileting. The facility further failed to follow a physician's order for a hand splint for 1 of 3 residents (Resident #5) who met the criteria for positioning and the facility failed to follow physician's orders for dycem (non-slip material) in the wheelchair for 1 of 5 residents (Resident #37) who met the criteria for accidents in the Stage 2 Sample of 26.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #65 on 10/21/11 at 9:02</p>		F0282	<p>F 282 SS: G Services by Qualified Persons/Per Care PlanIt is the policy of Riverbend Health Care Center to comply with regulatory requirement services provided by qualified persons per plan of care.Res#65 Facility is unable to apply specific corrective action due to resident discharge.Res #23 re-assessed for bladder toileting plan and care plan as indicated.Res #5 is currently on therapy caseload for evaluation and treatment for splint application per MD order.Res #37's Care Plan revised to include the intervention of dycum (non-slip material).1. Facility has re-assessed current resident's pain and current physicians orders for pain medication to ensure facility is meeting residents comfort needs.2. Facility has conducted a review of residents who are incontinent of bladder and on toileting programs to ensure care plan is accurate and implemented appropriately.Facility has conducted a review of residents with adaptive equipment(splints) per physicians order to ensure present and appropriately applied. Facility has conducted a review of residents who have fallen two or more times in the</p>		11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>a.m., indicated the following: diagnoses included, but were not limited to, carcinoma of left tongue with left cervical metastatic adenopathy, cachexia (weight loss and muscle wasting), COPD (chronic obstructive pulmonary disease), HTN (hypertension), and osteoarthritis.</p> <p>A physician order from the Oncologist for Resident #65, dated 10/4/11, indicated Lortab Elixir 7.5/500 mg 15 ml per G-tube every 4 hours PRN (as needed) for pain.</p> <p>A facility physician order for Resident #65, dated 10/7/11, indicated a Fentanyl patch 100 mcg/hr (micrograms per hour) once every three days for pain. PRN (as needed) pain medications included Acetaminophen 325-650 every 4 hours orally PRN, Acetaminophen 650 mg (milligrams) per feeding tube PRN and Lidocaine HCl 2% orally swish and spit every 4 hours PRN. The physician order did not indicate the resident was receiving the Lortab Elixir as ordered by the Oncologist.</p> <p>An Admission Medical History of Physical Examination written by the facility physician for Resident #65, indicated "...No history of any drug use...."</p>				<p>past 6 months from w/c to ensure care planned interventions are in place and effective.3. Licensed staff re-educated on facility policy and procedures related to: Fall risk and intervention management, bladder toilet programming, adaptive equipment, physician orders and pain management.Facility (IDT) will review new physician orders, therapy recommendations, residents with new onset pain or significant changes in condition, new assitive/splints application in the daily clinical meeting and update care plan as indicated.Pain assessments will be completed every shift and documentation on the resident medication administration record to ensure residents needs met.The facility interdisciplinary team (IDT) will review residents who have fallen in daily clinical meeting to ensure appropriate/effective interventions are implemented and care plan revised to reflect new interventions. Residents who have fallen referred to therapy post fall. DON or designee will QA new admission pain assessments and physician orders for pain medication to ensure availability of pain medication and effectiveness of pain medication x 3 months to assure accurate assessment.DON or designee will QA residents on toileting program daily x 2 weeks then weekly x 4</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>A facility physician order for Resident #65, dated 10/12/11, indicated to start Vicodin 5/500 mg orally every 4 hours PRN for pain when current supply of Vicodin was finished.</p> <p>A physician order from the Oncologist for Resident #65, dated 10/13/11, indicated Lortab Elixir 15 ml per G-tube (feeding tube) every 4 hours PRN for pain. A column next to the physician order for the Lortab Elixir had been marked "do not send".</p> <p>A facility care plan for Resident #65, dated 10/5/11, indicated a problem of alteration in comfort related to acute pain episodes related to cancer with goals to the problem included, but not limited to, will report pain less than daily and will experience decreased pain as evidence by verbalization of decrease in pain. Approaches to the problem included, but were not limited to, assess pain signs and symptoms, administer medication per order and monitor effectiveness, assess pain characteristics (location, duration, intensity [scale of 1-10], precipitating factors), and provide medication for break through pain per physician order.</p> <p>A facility care plan for Resident #65,</p>				<p>then monthly to ensure residents toileting needs are maintained per thr residents plan of care.DON or designee will conduct random visual observation of 2 residents daily x two weeks then weekly x 1 month then monthly to assure interventions for fall risk are in place as care planned.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations , until 100% compliance achieved times 3 months.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>dated 10/4/11, indicated a problem of alteration in comfort related to chronic pain due to cancer with a goal included, but not limited to, will experience decreased pain. Approaches to the problem included, but were not limited to, review pain medication management periodically, monitor and report effectiveness (sic) of drug to physician as needed, assess pain signs and symptoms, assess pain characteristics (location, duration, intensity [scale of 1-10] precipitating factors), administrator medication per order and assess effectiveness, and provide medication for break through pain per physician order.</p> <p>Facility Care Track for Resident #65, dated 10/4/11 at 6:00 p.m., indicated radiation burns in neck open to air. The Care Track also indicated pain to mouth rated @ (at) 8 and meds ordered awaiting delivery.</p> <p>Facility Care Track for Resident #65, dated 10/5/11 at 7:00 p.m., indicated complaint of pain, medicated for pain.</p> <p>Facility Care Track for Resident #65, dated 10/5/11 at 12:00 a.m., indicated "...resident c/o (complaint of) pain to neck et (and) requested pain medication. Resident pain medication</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>not in facility @ (at) this time. Writer attempted to retrieve medication from emergency drug kit but dosage needed not available. Writer contacted pharmacy to request stat order of medication be sent out due to resident request..Writer informed by pharmacy staff that medication is already in route from local pharmacy...." At 1:30 a.m., the Care Track indicated "...Resident medicated for pain as ordered...." At 9:30 a.m., Care Track indicated "...Resident with c/o pain/PRN medication given...." The Care Track further indicated the resident was having periods of discomfort during the 11P-7A shift, the 7A-3P shift, and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/5/11 at 5:35 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 7:00 p.m., Resident #65 indicated his pain remained an 8 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/6/11 at 1:00 a.m., indicated "...Resident complained of pain et requested pain medication. Resident medicated per request et order...." At 6:00 a.m., the Care Track indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>"...Resident c/o pain to neck et requested pain medication. Resident medicated per request et order...."</p> <p>The Care Track further indicated the resident was having periods of discomfort during 11P-7A shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/6/11 at 7:20 a.m., Resident #65 described his pain as a 6 out of 10 on the pain scale. At 8:20 a.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 12:00 p.m., Resident #65 described his pain as a 6 out of 10 on the pain scale. At 1:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/7/11 at 1:00 p.m., indicated "...Resident c/o pain to neck et mouth, requested pain medication. Resident medicated per request et order...." At 5:00 p.m., Care Track indicated "...Resident c/o pain to mouth et neck et requested pain medication. Resident medicated per request et order...." At 9:00 a.m., the Care Track indicated "...Res c/o throat et mouth pain not relived by routine mouth rinse. PRN Vicodin given at</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>this time...." With no time recorded, the Care Track indicated "...medicated x 2 for throat pain c (with) PRN Vicodin. Admits to relief...." The Care Track further indicated the resident was having periods of discomfort during 7A-3P shift and 3P-11P shift.</p> <p>Facility Care Track for Resident #65, dated 10/8/11 at 7:00 a.m., indicated "...Request PRN Vicodin x 2 for mouth pain...." At 10:00 a.m., the Care Track requested pain med for pain in face, throat...Vicodin given as per order. At 7:00 p.m., the Care Track indicate PRN Vicodin given for mouth pain, res alert et oriented...." The Care Track further indicated the resident was having periods of discomfort during 11P-7A shift and 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/8/11 at 10:00 a.m., Resident #65 described his pain as a 8 of out 10 on the pain scale. At 11:00 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/9/11 at 11:30 p.m., indicated "...Res request PRN Vicodin for c/o</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>jaw pain. Given as ordered...." At 3:30 a.m., the Care Track indicated "...Res request PRN Vicodin for c/o jaw pain. Given as ordered...." At 8:30 a.m., the Care Track indicated "...Requested Vicodin elx (elixir) for pain. 8 on pain scale. Pain in face et neck. Vicodin given as per order...." At 9:00 p.m., the Care Track indicated "...c/o of pain at 5 pm et 9 pm. Medicated at these times...." The Care Track further indicated the resident was having periods of discomfort during 11P-7A shift, 7A-3P shift and 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet on Resident #65, for the month of October 2011, indicated on 10/9/11 at 8:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 9:00 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale. At 1:00 p.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 2:00 p.m., Resident #65 described his pain as a 2 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/10/11 at 1:00 a.m., indicated "...Res up to nurses station requesting PRN Vicodin for c/o jaw pain. Given as ordered...." At 6:00 a.m., the Care Track indicated "...Res up at nurses</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>station requesting PRN Vicodin et Lidocaine. Given as ordered...." At 10:00 p.m., the Care Track indicated "...c/o of pain, Vicodin given...." The Care Track further indicated the resident was having periods of discomfort during the 11P-7A shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/10/11.</p> <p>Facility Care Track for Resident #65, dated 10/11/11 at 4:00 a.m., indicated "...Resident c/o pain to L (left) face et neck. Resident medicated per request et order...." At 12:00 p.m., the Care Track indicated "...Resident now request pain medication for d/t pain. Physician notified waiting reply...." The Care Track did not indicated any response had been received from the physician.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/11/11 at 8:45 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 9:45 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65,</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>dated 10/12/11 at 3:00 a.m., indicated "...Resident c/o pain to L face et neck. Resident medicated per request et order..." At 2:00 p.m., the Care Track indicated "...Medicated with PRN pain medication x 2 for c/o neck pain 7:30 am et 11:30 am...." At 3:30 p.m., the Care Track indicated "...Res requested PRN pain medication ...PRN Vicodin liquid...given...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/12/11 at 7:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:30 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale. At 11:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 12:30 p.m., Resident #65 described his pain as a 1 out of 10 on the pain scale. At 3:30 p.m., Resident #65 described his pain as an 8 out of 10 on the pain scale. At 5:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/13/11 at 6:00 a.m., indicated "...Resident c/o pain to L cheek. Resident medicated PRN pain as ordered...." At 9:00 a.m., the Care Track indicated "...Res returned from</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Dr appt (appointment), seen by Oncologist...Called Oncologist requesting clarification for Lortab Elixir order...." With no time recorded, the Care Track indicated "...Medicated c Vicodin @ 4:30p for c/o pain. Pain rated 9 on scale 1-10...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/13/11 at 9:30 a.m., Resident #65 described his pain as an 8 out of 10 on the pain scale. At 11:00 a.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/14/11 at 5:00 a.m., indicated "...Resident c/o pain et requested pain medication. Resident medicated per request et order...." At 8:00 a.m.,the Care Track indicated "...c/o neck pain/medicated with PRN pain medication...." With no time recorded, the Care Track indicated "...Medicated for neck pain x 1...." The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/14/11 at 8:00 a.m., Resident #65 described</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>his pain as a 10 out of 10 on the pain scale. At 9:00 a.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/15/11 at 12:00 p.m., indicated "...Res a (alert) &amp; o (oriented). C/o pain x 2 this shift. Given PRN Vicodin...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/15/11.</p> <p>Facility Care Track for Resident #65, dated 10/16/11 at 7:00 a.m., indicated "...Requested PRN Vicodin x 1 for c/o pain this a.m. Given as ordered...." At 9:00 a.m., the Care Track indicated "...C/o neck pain/medicated with PRN pain med...." At 6:00 p.m., the Care Track indicated "...Res a &amp; o et c/o pain et discomfort. Vicodin given @ 5pm c/o back pain et neck...." The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/16/11 at 12:00 a.m., Resident #65 described</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>his pain as a 10 out of 10. At 1:00 a.m., no improvement in pain had been noted. At 9:00 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:00 a.m., no improvement in pain had been noted. At 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 5:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 7:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/17/11 at 5:00 a.m., indicated "...Res requesting PRN Vicodin for c/o jaw pain. Given as ordered...." At 10:00 a.m., the Care Track indicated "...Request Vicodin for neck, head et jaw pain. Given as per order...." At 3:30 p.m., the Care Track indicated "...Medicated for pain. Again medicated at 7:30 pm for jaw pain. C/o H/A (headache) did medicate c Tylenol...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/17/11.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Facility Care Track for Resident #65, dated 10/18/11 at 2:00 a.m., indicated "...Resident c/o pain et requested pain medication. Resident medicated as ordered et requested...." With no time recorded, the Care Track indicated "...Resident requested Vicodin at 10am for neck, jaw et face pain...." With no time recorded, the Care Track indicated "...Medicated for L side neck pain x 1...." The Care Track further indicated the resident was having periods of discomfort during the 11P-7A shift, 7A-3P shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/18/11.</p> <p>Facility Care Track for Resident #65, dated 10/19/11 at 6:00 a.m., indicated "...Resident c/o pain et requested pain medication...." At 9:00 p.m., the Care Track indicated "...Res a &amp; o et c/o pain et discomfort @ this time. Pain meds given x 2 this shift...." The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>October 2011, indicated on 10/19/11 at 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 6:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/20/11 at 5:00 a.m., indicated "...Resident c/o pain et requested pain medication. Resident medicated per request et order...." At 2:00 p.m., the Care Track indicated "...Given PRN Tylenol for mouth discomfort...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/20/11 at 10:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 11:30 a.m., Resident #65 described his pain as a 2 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/21/11 at 8:30 a.m., indicated</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>"...C/o neck pain. Medicated with PRN pain medication..." At 11:00 a.m., the Care Track indicated "...call to Oncologist office r/t N.O. 10/13/11 Lortab Elixir. MD informed that medication not given. Order from facility physician 10/12/11 for Vicodin 5/500. Writer requested clarification on medication per office nurse. Continue to follow facility physician orders Vicodin 5/500 mg 1 po (orally) q (every) 4 hrs PRN pain until resident seen in office on 10/25/11. Order received et noted...." At 5:00 p.m., the Care Track indicated "...C/o neck pain medicated with Vicodin 5/500...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/21/11 at 8:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 10:00 a.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 2:30 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 3:30 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 5:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 6:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>A Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/22/11 at 7:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:30 a.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 12:30 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 1:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 4:30 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 6:00 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.</p> <p>A Progress Note for Resident #65, dated 10/23/11 at 7:30 a.m., indicated "...Request Vicodin for pain in face et neck. Rated 10 on pain scale. Given as per order...." At 12:00 p.m., the Care Track indicated "...Requested Vicodin for pain in neck et jaw. Rated 10 on pain scale. Given as per order...."</p> <p>A Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/23/11 at 7:30 a.m., indicated Resident #65 described his pain as a 10 out of 10 on the pain scale. At 9:00 a.m., Resident #65 indicated his pain was a</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>2 out of 10 on the pain scale. At 12:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 1:00 p.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 4:15 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 5:00 p.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 8:15 p.m., Resident #65 described his pain as a 10 of 10 on the pain scale. At 9:30 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>A Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/24/11 at 7:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:00 a.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.</p> <p>During an observation of Resident #65 on 10/20/11 at 3:30 p.m., Resident #65 approached the East med cart and requested pain medication from LPN #3 due to severe pain in his left jaw. LPN #3 instructed Resident #65 his new medication for pain had been ordered but not yet been sent from pharmacy and she would only be able to give</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>him a PRN pain med. The PRN pain medication for Acetaminophen 650 mg was administrated at that time.</p> <p>Review of the Medication Administration Record for Resident #65 for the month of October 2011 on 10/21/11 at 10:20 a.m., indicated the Lortab Elixir had not been added.</p> <p>Resident #65 was interviewed on 10/21/11 at 10:46 a.m. During the interview he indicated he had constant pain in his left jaw. He also indicated the facility only gave him Tylenol which did not help with the pain.</p> <p>LPN #5 was interviewed on 10/21/11 at 1:29 p.m. During the interview she indicated the nurse who recorded the order by the Oncologist had called Resident #65's facility physician to verify the order. LPN #5 also indicated the nurse on duty did not receive a call back from the primary physician regarding the order from Resident #65's Oncologist and marked do not send on the order form. LPN #5 further indicated the nurse failed to do any follow-up regarding the order for the Lortab Elixir, which was a stronger strength than the Vicodin. LPN #5 further indicated Resident #65's cognitive</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>status placed him as alert and oriented.</p> <p>The Social Services Director was interviewed on 10/21/11 at 1:39 p.m. During the interview she indicated Resident #65 was considered alert and oriented.</p> <p>The Director of Nursing was interviewed on 10/24/11 at 8:38 a.m. During the interview she indicated the facility did not have a policy on following physician orders.</p> <p>The Director of Nursing was interviewed on 10/24/11 at 8:47 a.m. During the interview she indicated the facility physician did not feel the Lortab Elixir dose was that much different from the order for the Vicodin. She also indicated the facility physician did not want to increase the dose of the Vicodin based on Resident #65's previous history with Vicodin at home. The facility physician would take care of the pain management for Resident #65. She also indicated the facility had not received any clarification on the order for the Lortab Elixir from the Oncologist and his notes from Resident #65's 10/13/11 appointment had not been recorded and sent to the facility as of this date. The</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Director of Nursing indicated the facility would be following the facility physician order for the Vicodin until Resident #65's next appointment with the Oncologist. She further indicated the order for the Lortab Elixir had been not been added to the MAR.</p> <p>A Medical Oncology and Hematology Report for Resident #65, dictated 10/16/11 and provided by the physician's office on 10/24/11 at 12:58 p.m., indicated a diagnoses of recurrent extensive squamous cell carcinoma of the tongue, status post hemiglossectomy and neck dissection. The report also indicated "...The patient...really has no complaints other than pain in his neck in and around the tumor...His neck shows about a 2-3 cm (centimeter) tumor in the anterior triangle of lower neck on the left side, which is clearly extensive tumor...he probably has incurable disease...this will not be a curable malignancy...He had a lot of pain in his mouth...."</p> <p>2. The record for Resident #23 was reviewed on 10/18/2011. Diagnoses included, but were not limited to, lumbar spine, cerebellar ataxia, HTN (hypertension), dementia, traumatic brain injury with expressive aphasia,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>history of carbon dioxide poisoning, anxiety, peptic ulcer, depression, psychosis, mood disorder, and benign prostatic hypertrophy.</p> <p>A Minimum Data Set Assessment dated 8/16/2011, indicated Resident #23 was frequently incontinent of urine and required the extensive assistance of one person for toileting.</p> <p>A care plan for Resident #23, with an on-set date of 5/16/2011 and a goal date of 11/26/2011, indicated Resident #23 was incontinent of urine. The goal was indicated as "pericare to be performed with staff assist after each incontinent episode thru (sic) next review." Interventions/approaches listed on the care plan included, but were not limited to, "check for incontinent episodes" and "assist to and from bathroom before and after each meal and prn (as needed)."</p> <p>On 10/18/2011 at 1:40 P.M. Resident #23 was observed sitting in his wheel chair in the West lounge. His gray sweat pants were observed to be wet in the groin area.</p> <p>On 10/20/2011, Resident #23 was continuously observed in the West lounge from 9:30 A.M. until 12:00</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>P.M., dressed in blue sweat pants, sitting in a wheel chair. At 12:00 P.M., Resident #23 was observed to look down at his lap. The groin area of his sweat pants was noted to be wet. At that time, the resident was observed to propel himself in his wheel chair down the hall to the nursing desk. He was observed to sit there for five minutes and then proceed to propel himself to the dining room. No staff were observed to interact with the resident or to check him during the observation period.</p> <p>CNA #11 was interviewed on 10/20/2011 at 11:00 A.M. During the interview, the CNA indicated Resident #23 was incontinent of urine and needed assistance with toileting and continence care. The CNA further indicated residents were to be either toileted or checked for incontinence every two hours and before and after meals. The CNA further indicated Resident #23 needed to be checked because he did not always tell the staff when he needed to be toileted.</p> <p>On 10/20/2011, Resident #23 was continuously observed in the West lounge from 1:00 P.M. until 3:15 P.M., dressed in the same sweat pants, sitting in his wheel chair. The groin of the sweat pants were observed to be</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>wet. At 3:15 P.M., CNA #10 was observed to propel Resident #23 to his room. The resident's sweat pants and adult brief was observed to be saturated with urine all the way down his thighs. CNA #10 was interviewed at that time. During the interview, the CNA indicated the day shift CNA had told her in report that she didn't check the resident since he was in bingo. The resident was never observed to attend bingo during the observations.</p> <p>The DON was interviewed on 10/21/11 at 2:15 P.M. During the interview the DON indicated staff were expected to check residents for incontinence or toilet them every 2 hours depending on the needs of the resident. She further indicated residents were to be toileted before</p> <p>A facility policy on bowel and bladder continence management, with a revision date of 8/2010, indicated "Interventions are provided to maintain dignity...."</p> <p>3. Review of the clinical record for resident #5 on 10/19/11 at 9:30 a.m. indicated the resident was admitted to the facility on 6/28/11 with diagnoses including, but not limited to, Hemiplegia left side, Diabetes, Neuropathy and Hypertension. Review of the Admission Minimum</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Data Set (MDS) assessment dated 7/6/11 indicated the resident had functional limitation on one side of the upper and lower extremity.</p> <p>Observation of the resident on 10/17/11 at 11:30 a.m. indicated the resident was in her wheelchair and her left arm was bent towards her left shoulder. Her left hand was contracted. Interview with the resident on 10/17/11 at 11:45 a.m. indicated she had lived at a different facility and had a hand splint but had not seen it since coming to the new facility.</p> <p>On 10/18/11 at 9:30 a.m. review of the resident's admission orders dated 6/28/11 indicated the resident was to wear a left hand splint during the day up to 6 hours and replace with a therapy carrot throughout the night as tolerated and an order to check skin before and after splint applied to left hand/arm wash and dry areas well before and after splint application.</p> <p>Interview with nurse # 6 on 10/18/11 at 11:00 a.m. indicated she did not know the resident was to have a hand/arm splint. During an observation of the resident on 10/18/11 at 3:00 p.m. the resident had a hand/arm splint. Interview with</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>the resident at that time indicated staff had found the splint in her closet.</p> <p>On 10/20/11 at 2:20 p.m. interview with CNA # 4 and #7 indicated they had never seen the resident wear a hand brace/splint.</p> <p>4. On 10/20/11 at 3:02 p.m., Resident #37 was observed in her room, no dycem was noted in the wheelchair.</p> <p>On 10/24/11 at 9:10 a.m., Resident #37 was observed in bed. The resident's wheelchair was sitting beside the bed with a pressure reducing cushion in the seat along with the hoyer sling pad. No dycem was observed.</p> <p>A review of the clinical record for Resident #37, on 10/17/11 at 2:30 p.m., indicated a telephone order, dated 1/15/11, for dycem to be placed on Resident #37's wheelchair seat.</p> <p>A condition change form, dated 1/15/11, indicated Resident #37 had an assisted fall from her wheelchair in the dining room. The form indicated Resident #37 slipped off the wheelchair seat and was assisted to the floor by staff.</p> <p>Nurse's Notes, dated 1/15/11 at 11:30</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>a.m., indicated Resident #37 was assisted to the floor after the resident slid from her wheelchair. The note further indicated the resident's hoyer pad was removed and dycem was placed in the chair.</p> <p>A facility care plan Potential for Falls, dated 3/24/11 with a goal date of 11/29/11, did not include the intervention of dycem in the wheelchair.</p> <p>CNA #4 was interviewed on 10/24/11 at 9:10 a.m. During the interview, CNA #4 indicated Resident #37 used to use dycem (non-slip material) but not anymore. She further indicated none was in the wheelchair currently, just a cushion.</p> <p>The current policy for Fall Risk Reduction &amp; Management, dated 8/10, was provided by the Director of Nursing on 10/21/11 at 10:00 a.m. The policy listed the following: "...The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence...Revise the care plan to indicate changes in interventions as indicated...Modify</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0309 SS=G	<p>and document goals and interventions as indicated...Communicate changes to the care giving team...."</p> <p>3.1-37(a)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to follow a physician's order for pain medication for 1 of 3 residents (Resident #65) who met the criteria for pain. This resulted in Resident #65 experiencing intense pain and requesting pain medication frequently.</p>			F0309	<p>F 309 SS: G Provide Care/Services for highest well being.It is the policy of Riverbend Health Care Center to comply with regulatory requirement Provide care/services for highest well being.1. Res#65 Facility is unable to apply specific corrective action due to resident discharge.Res #23 re-assessed</p>		11/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The facility also failed to ensure a hand splint was provided as ordered for 1 of 3 residents (Resident #5) who met the criteria for positioning.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #65 on 10/21/11 at 9:02 a.m., indicated the following: diagnoses included, but were not limited to, carcinoma of left tongue with left cervical metastatic adenopathy, cachexia (weight loss and muscle wasting), COPD (chronic obstructive pulmonary disease), HTN (hypertension), and osteoarthritis.</p> <p>A physician order from the Oncologist for Resident #65, dated 10/4/11, indicated Lortab Elixir 7.5/500 mg 15 ml per G-tube every 4 hours PRN (as needed) for pain.</p> <p>A facility physician order for Resident #65, dated 10/7/11, indicated a Fentanyl patch 100 mcg/hr (micrograms per hour) once every three days for pain. PRN (as needed) pain medications included Acetaminophen 325-650 every 4 hours orally PRN, Acetaminophen 650 mg (milligrams) per feeding tube PRN and Lidocaine HCl 2% orally</p>				<p>for bladder toileting plan and care plan as indicated. Res #5 is currently on therapy caseload for evaluation and treatment for splint application per MD order. 2. Facility has re-assessed current resident's pain and current physicians orders for pain medication to ensure facility is meeting residents comfort needs. Facility has conducted a review of residents with adaptive equipment (splints) per physicians order to ensure present and appropriately applied. 3. 3. Licensed staff re-educated on facility policy and procedures related to: , adaptive equipment, physician orders and pain management. Facility (IDT) will review new physician orders, residents with new onset pain or significant changes in condition, new assistive/splints application in the daily clinical meeting and update care plan as indicated. Pain assessments will be completed every shift and documentation on the resident medication administration record to ensure residents needs met. DON or designee will QA new admission pain assessments and physician orders for pain medication to ensure availability of pain medication and effectiveness of pain medication x 3 months. DON or designee will QA residents with adaptive devices (splints) by completing random visual observation daily x 2 weeks then weekly x 4 then</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>swish and spit every 4 hours PRN. The physician order did not indicate the resident was receiving the Lortab Elixir as ordered by the Oncologist.</p> <p>An Admission Medical History of Physical Examination written by the facility physician for Resident #65, indicated "...No history of any drug use...."</p> <p>A facility physician order for Resident #65, dated 10/12/11, indicated to start Vicodin 5/500 mg orally every 4 hours PRN for pain when current supply of Vicodin was finished.</p> <p>A physician order from the Oncologist for Resident #65, dated 10/13/11, indicated Lortab Elixir 15 ml per G-tube (feeding tube) every 4 hours PRN for pain. A column next to the physician order for the Lortab Elixir had been marked "do not send".</p> <p>A facility care plan for Resident #65, dated 10/5/11, indicated a problem of alteration in comfort related to acute pain episodes related to cancer with goals to the problem included, but not limited to, will report pain less than daily and will experience decreased pain as evidence by verbalization of decrease in pain. Approaches to the problem included, but were not limited</p>				<p>monthly to ensure adaptive devices are applied per physician order.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations, until 100% compliance is achieved times 3 months.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>to, assess pain signs and symptoms, administer medication per order and monitor effectiveness, assess pain characteristics (location, duration, intensity [scale of 1-10], precipitating factors), and provide medication for break through pain per physician order.</p> <p>A facility care plan for Resident #65, dated 10/4/11, indicated a problem of alteration in comfort related to chronic pain due to cancer with a goal included, but not limited to, will experience decreased pain. Approaches to the problem included, but were not limited to, review pain medication management periodically, monitor and report effectiveness (sic) of drug to physician as needed, assess pain signs and symptoms, assess pain characteristics (location, duration, intensity [scale of 1-10] precipitating factors), administrator medication per order and assess effectiveness, and provide medication for break through pain per physician order.</p> <p>Facility Care Track for Resident #65, dated 10/4/11 at 6:00 p.m., indicated radiation burns in neck open to air. The Care Track also indicated pain to mouth rated @(at) 8 and meds ordered awaiting delivery.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Facility Care Track for Resident #65, dated 10/5/11 at 7:00 p.m., indicated complaint of pain, medicated for pain.</p> <p>Facility Care Track for Resident #65, dated 10/5/11 at 12:00 a.m., indicated "...resident c/o (complaint of) pain to neck et (and) requested pain medication. Resident pain medication not in facility @ (at) this time. Writer attempted to retrieve medication from emergency drug kit but dosage needed not available. Writer contacted pharmacy to request stat order of medication be sent out due to resident request..Writer informed by pharmacy staff that medication is already in route from local pharmacy...." At 1:30 a.m., the Care Track indicated "...Resident medicated for pain as ordered...." At 9:30 a.m., Care Track indicated "...Resident with c/o pain/PRN medication given...." The Care Track further indicated the resident was having periods of discomfort during the 11P-7A shift, the 7A-3P shift, and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/5/11 at 5:35 p.m., Resident #65 described his pain as a 10 out of 10 on the pain</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>scale. At 7:00 p.m., Resident #65 indicated his pain remained an 8 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/6/11 at 1:00 a.m., indicated "...Resident complained of pain et requested pain medication. Resident medicated per request et order...." At 6:00 a.m., the Care Track indicated "...Resident c/o pain to neck et requested pain medication. Resident medicated per request et order...." The Care Track further indicated the resident was having periods of discomfort during 11P-7A shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/6/11 at 7:20 a.m., Resident #65 described his pain as a 6 out of 10 on the pain scale. At 8:20 a.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 12:00 p.m., Resident #65 described his pain as a 6 out of 10 on the pain scale. At 1:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/7/11 at 1:00 p.m., indicated "...Resident c/o pain to neck et mouth,</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>requested pain medication. Resident medicated per request et order...." At 5:00 p.m., Care Track indicated "...Resident c/o pain to mouth et neck et requested pain medication. Resident medicated per request et order...." At 9:00 a.m., the Care Track indicated "...Res c/o throat et mouth pain not relived by routine mouth rinse. PRN Vicodin given at this time...." With no time recorded, the Care Track indicated "...medicated x 2 for throat pain c (with) PRN Vicodin. Admits to relief...." The Care Track further indicated the resident was having periods of discomfort during 7A-3P shift and 3P-11P shift.</p> <p>Facility Care Track for Resident #65, dated 10/8/11 at 7:00 a.m., indicated "...Request PRN Vicodin x 2 for mouth pain...." At 10:00 a.m., the Care Track requested pain med for pain in face, throat...Vicodin given as per order. At 7:00 p.m., the Care Track indicate PRN Vicodin given for mouth pain, res alert et oriented...." The Care Track further indicated the resident was having periods of discomfort during 11P-7A shift and 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>October 2011, indicated on 10/8/11 at 10:00 a.m., Resident #65 described his pain as a 8 of out 10 on the pain scale. At 11:00 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/9/11 at 11:30 p.m., indicated "...Res request PRN Vicodin for c/o jaw pain. Given as ordered...." At 3:30 a.m., the Care Track indicated "...Res request PRN Vicodin for c/o jaw pain. Given as ordered...." At 8:30 a.m., the Care Track indicated "...Requested Vicodin elx (elixir) for pain. 8 on pain scale. Pain in face et neck. Vicodin given as per order...." At 9:00 p.m., the Care Track indicated "...c/o of pain at 5 pm et 9 pm. Medicated at these times...." The Care Track further indicated the resident was having periods of discomfort during 11P-7A shift, 7A-3P shift and 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet on Resident #65, for the month of October 2011, indicated on 10/9/11 at 8:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 9:00 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale. At 1:00 p.m., Resident #65 described his pain as a 9 out of</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>10 on the pain scale. At 2:00 p.m., Resident #65 described his pain as a 2 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/10/11 at 1:00 a.m., indicated "...Res up to nurses station requesting PRN Vicodin for c/o jaw pain. Given as ordered...." At 6:00 a.m., the Care Track indicated "...Res up at nurses station requesting PRN Vicodin et Lidocaine. Given as ordered...." At 10:00 p.m., the Care Track indicated "...c/o of pain, Vicodin given...." The Care Track further indicated the resident was having periods of discomfort during the 11P-7A shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/10/11.</p> <p>Facility Care Track for Resident #65, dated 10/11/11 at 4:00 a.m., indicated "...Resident c/o pain to L (left) face et neck. Resident medicated per request et order...." At 12:00 p.m., the Care Track indicated "...Resident now request pain medication for d/t pain. Physician notified waiting reply...." The Care Track did not indicated any response had been received from the physician.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/11/11 at 8:45 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 9:45 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/12/11 at 3:00 a.m., indicated "...Resident c/o pain to L face et neck. Resident medicated per request et order..." At 2:00 p.m., the Care Track indicated "...Medicated with PRN pain medication x 2 for c/o neck pain 7:30 am et 11:30 am...." At 3:30 p.m., the Care Track indicated "...Res requested PRN pain medication ...PRN Vicodin liquid...given...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/12/11 at 7:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:30 a.m., Resident #65 described his pain as a 1 out of 10 on the pain scale. At 11:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 12:30 p.m., Resident #65 described his pain as a 1 out of 10 on the pain scale. At 3:30 p.m., Resident #65 described his pain as an 8 out of 10</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>on the pain scale. At 5:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/13/11 at 6:00 a.m., indicated "...Resident c/o pain to L cheek. Resident medicated PRN pain as ordered...." At 9:00 a.m., the Care Track indicated "...Res returned from Dr appt (appointment), seen by Oncologist...Called Oncologist requesting clarification for Lortab Elixir order...." With no time recorded, the Care Track indicated "...Medicated c Vicodin @ 4:30p for c/o pain. Pain rated 9 on scale 1-10...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/13/11 at 9:30 a.m., Resident #65 described his pain as an 8 out of 10 on the pain scale. At 11:00 a.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/14/11 at 5:00 a.m., indicated "...Resident c/o pain et requested pain medication. Resident medicated per request et order...." At 8:00 a.m.,the Care Track indicated "...c/o neck pain/medicated with PRN pain medication...." With no time</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>recorded, the Care Track indicated "...Medicated for neck pain x 1...."</p> <p>The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/14/11 at 8:00 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 9:00 a.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/15/11 at 12:00 p.m., indicated "...Res a (alert) &amp; o (oriented). C/o pain x 2 this shift. Given PRN Vicodin...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/15/11.</p> <p>Facility Care Track for Resident #65, dated 10/16/11 at 7:00 a.m., indicated "...Requested PRN Vicodin x 1 for c/o pain this a.m. Given as ordered...." At 9:00 a.m., the Care Track indicated "...C/o neck pain/medicated with PRN pain med...." At 6:00 p.m., the Care Track indicated "...Res a &amp; o et c/o pain et discomfort. Vicodin given @</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>5pm c/o back pain et neck...." The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/16/11 at 12:00 a.m., Resident #65 described his pain as a 10 out of 10. At 1:00 a.m., no improvement in pain had been noted. At 9:00 a.m., Resident #65 described his pain as a 10 of out 10 on the pain scale. At 10:00 a.m., no improvement in pain had been noted. At 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 5:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 7:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>Facility Care Track for Resident #65, dated 10/17/11 at 5:00 a.m., indicated "...Res requesting PRN Vicodin for c/o jaw pain. Given as ordered...." At 10:00 a.m., the Care Track indicated "...Request Vicodin for neck, head et jaw pain. Given as per order...." At 3:30 p.m., the Care Track indicated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>"...Medicated for pain. Again medicated at 7:30 pm for jaw pain. C/o H/A (headache) did medicate c Tylenol...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/17/11.</p> <p>Facility Care Track for Resident #65, dated 10/18/11 at 2:00 a.m., indicated "...Resident c/o pain et requested pain medication. Resident medicated as ordered et requested...." With no time recorded, the Care Track indicated "...Resident requested Vicodin at 10am for neck, jaw et face pain...." With no time recorded, the Care Track indicated "...Medicated for L side neck pain x 1...." The Care Track further indicated the resident was having periods of discomfort during the 11P-7A shift, 7A-3P shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, did not have an entry for 10/18/11.</p> <p>Facility Care Track for Resident #65, dated 10/19/11 at 6:00 a.m., indicated "...Resident c/o pain et requested pain medication...." At 9:00 p.m., the Care</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Track indicated "...Res a &amp; o et c/o pain et discomfort @ this time. Pain meds given x 2 this shift...." The Care Track further indicated the resident was having periods of discomfort during the 7A-3P shift and the 3P-11P shift.</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/19/11 at 1:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 2:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 6:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:00 p.m., Resident #65 described his pain as a 3 out of 10. At 10:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/20/11 at 5:00 a.m., indicated "...Resident c/o pain et requested pain medication. Resident medicated per request et order...." At 2:00 p.m., the Care Track indicated "...Given PRN Tylenol for mouth discomfort...."</p> <p>A facility Pain Intervention Flowsheet</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>for Resident #65, for the month of October 2011, indicated on 10/20/11 at 10:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 11:30 a.m., Resident #65 described his pain as a 2 out of 10 on the pain scale.</p> <p>Facility Care Track for Resident #65, dated 10/21/11 at 8:30 a.m., indicated "...C/o neck pain. Medicated with PRN pain medication..." At 11:00 a.m., the Care Track indicated "...call to Oncologist office r/t N.O. 10/13/11 Lortab Elixir. MD informed that medication not given. Order from facility physician 10/12/11 for Vicodin 5/500. Writer requested clarification on medication per office nurse. Continue to follow facility physician orders Vicodin 5/500 mg 1 po (orally) q (every) 4 hrs PRN pain until resident seen in office on 10/25/11. Order received et noted...." At 5:00 p.m., the Care Track indicated "...C/o neck pain medicated with Vicodin 5/500...."</p> <p>A facility Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/21/11 at 8:30 a.m., Resident #65 described his pain as a 9 out of 10 on the pain scale. At 10:00 a.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 2:30 p.m., Resident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>#65 described his pain as a 10 out of 10 on the pain scale. At 3:30 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective. At 5:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 6:00 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>A Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/22/11 at 7:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 8:30 a.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 12:30 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 1:30 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale. At 4:30 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 6:00 p.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.</p> <p>A Progress Note for Resident #65, dated 10/23/11 at 7:30 a.m., indicated "...Request Vicodin for pain in face et neck. Rated 10 on pain scale. Given as per order...." At 12:00 p.m., the Care Track indicated "...Requested Vicodin for pain in neck et jaw. Rated</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>10 on pain scale. Given as per order...."</p> <p>A Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/23/11 at 7:30 a.m., indicated Resident #65 described his pain as a 10 out of 10 on the pain scale. At 9:00 a.m., Resident #65 indicated his pain was a 2 out of 10 on the pain scale. At 12:00 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 1:00 p.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 4:15 p.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 5:00 p.m., Resident #65 described his pain as a 2 out of 10 on the pain scale. At 8:15 p.m., Resident #65 described his pain as a 10 of 10 on the pain scale. At 9:30 p.m., the Pain Intervention Flowsheet indicated the pain medication was effective.</p> <p>A Pain Intervention Flowsheet for Resident #65, for the month of October 2011, indicated on 10/24/11 at 7:30 a.m., Resident #65 described his pain as a 10 out of 10 on the pain scale. At 10:00 a.m., Resident #65 described his pain as a 3 out of 10 on the pain scale.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>During an observation of Resident #65 on 10/20/11 at 3:30 p.m., Resident #65 approached the East med cart and requested pain medication from LPN #3 due to severe pain in his left jaw. LPN #3 instructed Resident #65 his new medication for pain had been ordered but not yet been sent from pharmacy and she would only be able to give him a PRN pain med. The PRN pain medication for Acetaminophen 650 mg was administered at that time.</p> <p>Review of the Medication Administration Record for Resident #65 for the month of October 2011 on 10/21/11 at 10:20 a.m., indicated the Lortab Elixir had not been added.</p> <p>Resident #65 was interviewed on 10/21/11 at 10:46 a.m. During the interview he indicated he had constant pain in his left jaw. He also indicated the facility only gave him Tylenol which did not help with the pain.</p> <p>LPN #5 was interviewed on 10/21/11 at 1:29 p.m. During the interview she indicated the nurse who recorded the order by the Oncologist had called Resident #65's facility physician to verify the order. LPN #5 also indicated the nurse on duty did not</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>receive a call back from the primary physician regarding the order from Resident #65's Oncologist and marked do not send on the order form. LPN #5 further indicated the nurse failed to do any follow-up regarding the order for the Lortab Elixir, which was a stronger strength than the Vicodin. LPN #5 further indicated Resident #65's cognitive status placed him as alert and oriented.</p> <p>The Social Services Director was interviewed on 10/21/11 at 1:39 p.m. During the interview she indicated Resident #65 was considered alert and oriented.</p> <p>The Director of Nursing was interviewed on 10/24/11 at 8:38 a.m. During the interview she indicated the facility did not have a policy on following physician orders.</p> <p>The Director of Nursing was interviewed on 10/24/11 at 8:47 a.m. During the interview she indicated the facility physician did not feel the Lortab Elixir dose was that much different from the order for the Vicodin. She also indicated the facility physician did not want to increase the dose of the Vicodin based on Resident #65's previous</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>history with Vicodin at home. The facility physician would take care of the pain management for Resident #65. She also indicated the facility had not received any clarification on the order for the Lortab Elixir from the Oncologist and his notes from Resident #65's 10/13/11 appointment had not been recorded and sent to the facility as of this date. The Director of Nursing indicated the facility would be following the facility physician order for the Vicodin until Resident #65's next appointment with the Oncologist. She further indicated the order for the Lortab Elixir had been not been added to the MAR.</p> <p>A Medical Oncology and Hematology Report for Resident #65, dictated 10/16/11 and provided by the physician's office on 10/24/11 at 12:58 p.m., indicated a diagnoses of recurrent extensive squamous cell carcinoma of the tongue, status post hemiglossectomy and neck dissection. The report also indicated "...The patient...really has no complaints other than pain in his neck in and around the tumor...His neck shows about a 2-3 cm (centimeter) tumor in the anterior triangle of lower neck on the left side, which is clearly extensive tumor...he probably has incurable disease...this will not be a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>curable malignancy...He had a lot of pain in his mouth...."</p> <p>A current facility policy "Pain Management", revised on 8/10, indicated "...The facility strives to improve resident/patient comfort and minimize the experience of pain as much as possible...."</p> <p>2. Review of the clinical record for resident #5 on 10/19/11 at 9:30 a.m. indicated the resident was admitted to the facility on 6/28/11 with diagnoses including, but not limited to, Hemiplegia left side, Diabetes, Neuropathy and Hypertension. Review of the Admission Minimum Data Set (MDS) assessment dated 7/6/11 indicated the resident had functional limitation on one side of the upper and lower extremity.</p> <p>Observation of the resident on 10/17/11 at 11:30 a.m. indicated the resident was in her wheelchair and her left arm was bent towards her left shoulder. Her left hand was contracted. Interview with the resident on 10/17/11 at 11:45 a.m. indicated she had lived at a different facility and had a hand splint but had not seen it since coming to the new facility.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>On 10/18/11 at 9:30 a.m. review of the resident's admission orders dated 6/28/11 indicated the resident was to wear a left hand splint during the day up to 6 hours and replace with a therapy carot throughout the night as tolerated, and an order to check skin before and after splint applied to left hand/arm wash and dry areas well before and after splint application.</p> <p>Interview with nurse # 6 on 10/18/11 at 11:00 a.m. indicated she did not know the resident was to have a hand/arm splint. During an observation of the resident on 10/18/11 at 3:00 p.m. the resident had a hand/arm splint. Interview with the resident at that time indicated staff had found the splint in her closet.</p> <p>On 10/20/11 at 2:20 p.m. interview with CNA # 4 and #7 indicated they had never seen the resident wear a hand brace/splint.</p> <p>3.1-37(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0311 SS=D	<p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on record review and interview, the facility failed to provide restorative therapy as documented in the annual MDS for 1 of 5 residents (Resident #53) who met the criteria for activities of daily living.</p> <p>Findings include:</p> <p>Resident #53's record was reviewed on 10/19/11 at 10:10 a.m. The record indicated Resident #53's diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, and cerebrovascular accident.</p> <p>The care plan for decreased range of motion, dated 9/1/11, with a goal date of 12/25/11, indicated Resident #53 would participate in a restorative program.</p> <p>The facility had not addressed the interventions for restorative ambulation and transfers in the resident's care plans.</p>		F0311	<p>F 311 SS: D Treatment/Services to maintain ADL'slt is the policy of Riverbend Health Care Center to comply with regulatory requirement treatment/services to maintain ADL's.1. Res # 53 re-assessed by nursing for appropriate restorative plan. Res #53 screen by therapy for additional restorative intervention as appropriate.2. Facility nursing will review resident last two MDS assessments and compare for a decline in function per MDS section G, if decline is noted then resident's will be referred to therapy for screen to determine if restorative program would be beneficial to resident.3. Licensed staff re-educated on facility policy and procedures related to: restorative program.The IDT will review in daily clinical meeting residents who have a functional decline and will refer to therapy for screening for restorative programming.DON or designee will QA restorative documentation weekly x 3 months to ensure that restorative program completed per physician order and documented accurately.4. Results from QA reviews will be forwarded to the Facility Risk</p>		11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The annual Minimum Data Set (MDS) assessment, dated 9/2/11, indicated Resident #53 received restorative therapy for walking on three days and restorative transferring on six days.</p> <p>The restorative program for Resident #53 was provided by the Unit Manager on 10/21/11 at 2:00 p.m. The documentation listed Resident #53 as having an ambulation and transfer restorative program.</p> <p>Computer documentation of restorative therapy from 8/26/11 until 10/24/11 was provided by the Director of Nursing on 10/24/11 at 1:40 p.m. There was no documentation in the computer charting of any restorative therapy for Resident #53.</p> <p>The MDS nurse was interviewed on 10/24/11 at 1:10 p.m. During the interview, the MDS nurse indicated the MDS and how it is coded affects the amount of payment the facility receives. She further indicated for restorative therapy, there must be documentation of at least 15 minutes of therapy. When there is at least two sessions of restorative [days], this would increase the "RUG" category [amount of money the facility would receive].</p>				<p>Management Quality Improvement (RMQI) committee for further review and recommendations, until 100% compliance is achieved times 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0312 SS=D	<p>3.1-38(a)(2)(B)</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to provide documentation of a bladder assessment and document the frequency of toileting needed for 1 of 5 residents (Resident #37) who met the criteria for toileting. The facility also failed to toilet 2 of 5 residents (Resident #37 and Resident #23) who met the criteria for toileting in the Stage 2 Sample of 36.</p> <p>Findings include:</p> <p>1. Resident #37's record was reviewed on 10/17/11 at 2:30 p.m. The record indicated Resident #37's diagnoses included, but were not limited to, congestive heart failure,</p>	F0312	<p>F 312 SS: D ADL care provided for dependent resident. It is the policy of Riverbend Health Care Center to comply with regulatory requirement ADL care is provided for dependent resident. 1. Resident #37 re-assessed for bladder incontinence and care plan revised as indicated. Res #23 re-assessed for bladder toileting plan and care plan as indicated. 2. Facility reviewed residents to ensure bladder assessments completed. Facility has conducted a review of residents who are incontinent of bladder and on toileting programs to ensure care plan is accurate and implemented appropriately per documentation. 3. Licensed staff re-educated on facility policy and procedures related to: bladder incontinence and toileting program. Nursing staff</p>	11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>coronary artery disease, depression, dementia, and osteoarthritis. No documentation of a bladder assessment was noted in the clinical record during record review.</p> <p>Resident #37 was observed from 9:50 a.m. until 2:00 p.m. on 10/20/11. The resident was not toileted or incontinence brief changed during this time period.</p> <p>Resident #37 was observed on 10/21/11 at 8:48 a.m., being wheeled back to her room by CNA #4 after breakfast. At 10:27 a.m., CNA #4 took the resident to an activity. The resident was not observed to be toileted or the incontinence brief changed. At 1:33 p.m., the resident was put in bed and the resident's incontinence brief was changed.</p> <p>The current care plan for alteration in urinary elimination, dated 9/22/10, with a goal date of 11/29/11, indicated to check for incontinent episodes and assist as necessary. There was no specifics on how often to check the resident for incontinence.</p> <p>The annual Minimum Data Set (MDS) Assessment, dated 9/2/11, indicated Resident #37 was frequently incontinent of bladder and always</p>				<p>re-educated on facility policy and procedure related to bladder assessments.IDT will review in daily clinical meeting residents coded, as a change in continence re-assessed and care plan revised and implemented as indicated. DON or designee will QA residents on toileting program daily x 2 weeks then weekly x 4 then monthly to ensure residents toileting needs are maintained per thr residents plan of care.DON or designee will QA new admission for bladder assessments and toileting plans x 3 months for accurate assessments.4. Results from QA reviews will be forwarded to the facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations, until 100% compliance is achieved times 3 months.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>incontinent of bowel.</p> <p>The most current Care Tracker (computer program) for CNAs, printed on 10/21/11, indicated Resident #37 was incontinent of bowel and bladder but did not indicate how often to check the resident for incontinence.</p> <p>An interview was conducted with CNA #4 on 10/21/11 at 1:33 p.m. During the interview, CNA #4 indicated Resident #37 should be checked every two hours for incontinence.</p> <p>1. The record for Resident #23 was reviewed on 10/18/2011. Diagnoses included, but were not limited to, lumbar spine, cerebellar ataxia, HTN, dementia, traumatic brain injury with expressive aphasia, history of carbon dioxide poisoning, anxiety, peptic ulcer, depression, psychosis, mood disorder, and benign prostatic hypertrophy.</p> <p>A Minimum Data Set Assessment dated 8/16/2011, indicated Resident #23 was frequently incontinent of urine and required the extensive</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>assistance of one person for toileting.</p> <p>A care plan for Resident #23, with an on-set date of 5/16/2011 and a goal date of 11/26/2011, indicated Resident #23 was incontinent of urine. The goal was indicated as "pericare to be performed with staff assist after each incontinent episode thru (sic) next review." Interventions/approaches listed on the care plan included, but were not limited to, "check for incontinent episodes" and "assist to and from bathroom before and after each meal and prn (as needed)."</p> <p>On 10/18/2011 at 1:40 P.M. Resident #23 was observed sitting in his wheel chair in the West lounge. His gray sweat pants were observed to be wet in the groin area.</p> <p>On 10/20/2011, Resident #23 was continuously observed in the West lounge from 9:30 A.M. until 12:00 P.M., dressed in blue sweat pants, sitting in a wheel chair. At 12:00 P.M., Resident #23 was observed to look down at his lap. The groin area of his sweat pants was noted to be wet. At that time, the resident was observed to propel himself in his wheel chair down the hall to the nursing desk. He was observed to sit there for five</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>minutes and then proceed to propel himself to the dining room. No staff were observed to interact with the resident or to check him during the observation period.</p> <p>CNA #11 was interviewed on 10/20/2011 at 11:00 A.M. During the interview, the CNA indicated that Resident #23 was incontinent of urine and needed assistance with toileting and continence care. The CNA further indicated residents were to be either toileted or checked for incontinence every two hours and before and after meals. The CNA further indicated Resident #23 needed to be checked because he did not always tell the staff when he needed to be toileted.</p> <p>On 10/20/2011, Resident #23 was continuously observed in the West lounge from 1:00 P.M. until 3:15 P.M., dressed in the same seat pants, sitting in his wheel chair. The groin of the sweat pants were observed to be wet. At 3:15 P.M., CNA #10 was observed to propel Resident #23 to his room. The resident's sweat pants and adult brief was observed to be saturated with urine all the way down his thighs. CNA #10 was interviewed at that time. During the interview, the CNA indicated the day shift CNA had</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0323 SS=D	<p>told her in report that she didn't check the resident since he was in bingo. The resident was never observed to attend bingo during the observations.</p> <p>The DON was interviewed on 10/21/11 at 2:15 P.M. During the interview the DON indicated staff were expected to check residents for incontinence or toilet them every 2 hours depending on the needs of the resident. She further indicated residents were to be toileted before and after meals.</p> <p>A facility policy on bowel and bladder continence management, with a revision date of 8/2010, indicated "Interventions are provided to maintain dignity...."</p> <p>3.1-38(a)(2)(C)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to update the fall care plan with the</p>			F0323	F 323 SS: D Free of Accidents and HazardsIt is the policy of Riverbend Health Care Center to comply with regulatory requirement free of accidents and		11/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>implementation of the dycem (non-slip material) in the wheelchair for 1 of 5 residents (Resident #37) who met the criteria for accidents in the Stage 2 Sample of 26.</p> <p>Findings include:</p> <p>On 10/20/11 at 3:02 p.m., Resident #37 was observed in her room, no dycem was noted in the wheelchair.</p> <p>On 10/24/11 at 9:10 a.m., Resident #37 was observed in bed. The resident's wheelchair was sitting beside the bed with a pressure reducing cushion in the seat along with the hoyer sling pad. No dycem was observed.</p> <p>A review of the clinical record for Resident #37, on 10/17/11 at 2:30 p.m., indicated a telephone order, dated 1/15/11, for dycem to be placed on Resident #37's wheelchair seat.</p> <p>A condition change form, dated 1/15/11, indicated Resident #37 had an assisted fall from her wheelchair in the dining room. The form indicated Resident #37 slipped off the wheelchair seat and was assisted to the floor by staff.</p> <p>Nurse's Notes, dated 1/15/11 at 11:30</p>				<p>hazards.1. Res #37's Care Plan revised to include the intervention of dycum (non-slip material).2. The facility has conducted a review of residents who have fallen two or more times in the past 6 months from w/c to insure care planned interventions are in place and effective.3. Licensed staff will be re-educated on facility policy and procedure related to fall risk and implementation of care-planned interventions are in place and effective.The facility interdisciplinary team (IDT) will review residents who have fallen in daily clinical meeting to ensure appropriate/effective interventions are implemented and care plan revised to reflect new interventions. Residents who have fallen referred to therapy post fall. DON or designee will conduct random visual observation of 2 residents daily x two weeks then weekly x 1 month then monthly to assure interventions for fall risk are in place as care planned.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations as indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>a.m., indicated Resident #37 was assisted to the floor after the resident slid from her wheelchair. The note further indicated the resident's hoyer pad was removed and dycem was placed in the chair.</p> <p>A facility care plan Potential for Falls, dated 3/24/11 with a goal date of 11/29/11, did not include the intervention of dycem in the wheelchair.</p> <p>CNA #4 was interviewed on 10/24/11 at 9:10 a.m. During the interview, CNA #4 indicated Resident #37 used to use dycem (non-slip material) but not anymore. She further indicated none was in the wheelchair currently, just a cushion.</p> <p>The current policy for Fall Risk Reduction &amp; Management, dated 8/10, was provided by the Director of Nursing on 10/21/11 at 10:00 a.m. The policy listed the following: "...The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence...Revise the care plan to indicate changes in interventions as indicated...Modify</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0329 SS=D	<p>and document goals and interventions as indicated...Communicate changes to the care giving team...."</p> <p>3.1-45(a)(2)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a gradual dose reduction (GDR) was attempted</p>	F0329	F 329 SS: Drug Regimen is free from unnecessary drugs.It is the policy of Riverbend Health Care	11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>or documentation obtained from the physician regarding the rationale for not attempting a GDR for 2 of 10 residents (Resident #37 and Resident #10) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1. Resident #37's record was reviewed on 10/17/11 at 2:30 p.m. The record indicated Resident #37's diagnoses included, but were not limited to, congestive heart failure, coronary artery disease, depression, dementia, and osteoarthritis.</p> <p>An Admission Order Plan of Care for Resident #37, dated 8/6/10, indicated the resident was receiving celexa (antidepressant) 20 mg every day.</p> <p>A Pharmacy Consultant Report, dated 11/11/10, indicated Resident #37 "has taken citalopram (celexa) 20 mg QD (every day) for management of major depressive disorder since 8/09...please consider documenting that gradual dose reduction (GDR) is clinically contraindicated...." The physician signed the report December 2010 declining the recommendation for GDR but did not document rationale.</p>				<p>Center to comply with regulatory requirement drug regimen is free from unnecessary drugs.1. Res #37 re-assessed by physician and a gradual dose reduction has been acted on. Res #10 re-assessed by physician and documentation on GDR has been completed.2. Facility has reviewed pharmacy GDR recommendation, past 60 days, to ensure physician has documented rational as to why reduction not attempted.3. Administrator to re-educate facility physician on regulation 329 and GDR documentation.IDT will review GDR in monthly care review meeting to ensure documentation reflects rational as to why reduction not attempted or recommendation not accepted by MD.Social Service or designee will QA monthly pharmacy GDR recommendations for appropriate documentation by physician includes rational as to why reduction not attempted.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations as indicated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>A Pharmacy Consultant Report, dated 09/28/11, indicated "Repeated recommendation from 6/20/11" for GDR of citalopram. The report indicated Resident #37 was receiving citalopram 20 mg every day since 8/09. The report was not signed until 10/7/11 confirming a GDR is appropriate.</p> <p>The Director of Nursing (DON) was interviewed on 10/24/11 at 8:15 a.m. During the interview, the DON indicated the facility does not have a policy and procedure for Pharmacy Consultant Reports. She indicated the reports are given to the physician for signature or follow-up.</p> <p>2. Resident #10's record was reviewed on 10/17/11 at 3:00 p.m. The record indicated Resident #10's diagnoses included, but were not limited to, depression, fibromyalgia, and multiple sclerosis.</p> <p>A Pharmacy Consultant Report, dated 4/18/11, indicated "has taken cymbalta 60 mg every day since 3/15/09 for management of depressive symptoms...please consider a gradual dose reduction...." There was no documentation by the physician on the form indicating why a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0333 SS=A	<p>GDR was not to be attempted.</p> <p>A Pharmacy Consultant Report, dated 10/19/10, indicated "has taken cymbalta 60 mg every day since 3/15/09 for management of depressive symptoms...please consider a gradual dose reduction...." There was no documentation by the physician on the form indicating why a GDR was not to be attempted.</p> <p>3.1-48(a)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure each resident received the correct medication for 1 of 10 residents (Resident #37) reviewed for medications in a Stage 2 Sample of 36.</p> <p>Findings include:</p> <p>A "Medication Error Report" dated</p>		F0333	<p>F 333 SS: A Resident Free from significant med errorsIt is the policy of Riverbend Health Care Center to comply with regulatory requirement free from med errors.1. Res #37 unable to complete corrective action for resident at this time.2. DON or designee QA orders against MARS/TARS to insure accuracy of orders on. No other errors notified.3. Licensed nursing staff re-educated on the facility policy and procedure related to</p>		11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>1/13/11, indicated Resident #37 was given her roommate's medications [Resident #22] in error on 1/13/11 at 2:00 p.m. Time was initially documented as 1:30 p.m. but was crossed out. The residents name was initially listed as Resident #22 but was crossed out and replaced with Resident #37. The physician's name was crossed out and changed as well as the name of the supervisor notified.</p> <p>The Medication Error Report, dated 1/13/11, indicated Resident #37 was given her roommate's medications: calcium 600 mg, benztropine 2 mg [anti-parkinsons drug], senna 1 tab [stimulant laxative], topamax 25 mg [anti-seizure medication]. Ibuprofen [nonsteroidal anti-inflammatory drug] and Geodon 60 mg [antipsychotic] was crossed out. The report was left blank for the reason of the error and measures taken to prevent the recurrence of similar error(s).</p> <p>The Medication Record for Resident #22 for January 2011, indicated the following afternoon medication [4:00 p.m.]: benztropine 2 mg, geodon 60 mg, senna laxative, topamax 25 mg, calcium 600 with vitamin D and advair 50/100 one puff.</p>			<p>principles of medication administration and regulations related to significant medication errors.DON or designee will QA five random charts weekly x 4 weeks then monthly for accuracy of MARS/TARS matching physicians orders. The same five residents that have a chart review will have a medication pass observation conducted at the same time to assure licensed nursing staff follows policy related to medication administration.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations as indicated.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>A facility care plan for Impaired Memory for Resident #22, with a start date of 12/17/10 and a goal date of 11/29/11, indicated she had both short and long term memory deficits and moderate cognitive impairment.</p> <p>The employee file was reviewed on 10/25/11 at 2:00 p.m. for the nurse making the medication error [RN #12]. The employee file indicated the nurse was later terminated due to poor job performance. The file also indicated RN #12 did not notify the DON or Administrator of a resident going to the hospital and also that the nurse had left medications at the bedside of a resident and had not checked to make sure the resident took the meds. The hire date for the nurse was listed as 1/12/11 with her receiving her RN status effective 9/19/85.</p> <p>The Director of Nursing (DON) was interviewed on 10/25/11 at 11:15 a.m. During the interview, she indicated she could not find any other documentation on the incident report.</p> <p>3.1-25(b)(9)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0356 SS=D	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview the facility failed to ensure the daily nursing hours posted had the correct date and was easily accessible for residents and visitors on 1 of 6 days observed. This had the potential to affect 46 of 46 residents and their</p>			F0356	<p>F 356 SS: D Posted nurse staffing informationIt is the policy of Riverbend Health Care Center to comply with regulatory requirement posting nursing staffing information.1. Nurse staffing posted is now at w/c level with correct date and information.2. No residents were affected by the practice.3. DON</p>		11/23/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0371 SS=F	<p>visitors.</p> <p>Finding Includes:</p> <p>During the initial tour on 10/17/11 at 10:30 a.m. observation of the daily nursing hours posted were dated 10/14/11. The posting was noted to be on the wall next to the beauty shop at eye level. On 10/18/11 the posting had the correct date.</p> <p>On 10/20/11 at 2:00 p.m. the administrator was informed of the posting having the wrong date on 10/17/11 and that it was not accessible to people in wheelchairs.</p> <p>3.1-13(a)</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review</p>	F0371	<p>or designee will monitor daily staffing x 1 daily, then weekly x 4 weeks. Then monthly x 2 months.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations, until 100% compliance is achieved times 3 months.</p> <p>F 371 SS: F Food procurement store/prepare serve sanitaryIt is</p>	11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>and interview, the facility failed to ensure dishes were washed using appropriate levels of sanitizer solution in the dish machine and failed to submerge dishes in the three compartment sink for the appropriate length of time for sanitization process. The facility further failed to ensure Dietary Staff #2 handled food with gloves or utensils and washed hands per policy. This had the potential to affect 45 of 46 residents who ate food prepared by the facility kitchen.</p> <p>Findings include:</p> <p>1. On 10/17/11 at 9:40 a.m., dishes were observed being washed in the main dish machine by Dietary #2. When queried, Dietary Staff #2 indicated test strips are used to check the sanitization levels every morning and at different times during the day on the documentation log on the wall. No documentation was noted for the evening of 10/16/11 and for 10/17/11. The staff member then proceeded to test the sanitizing solution in the dish machine but was unable to get the test strips to register after four attempts.</p> <p>On 10/17/11 at 9:42 a.m., the three compartment sink was observed with one sink filled with soap, one sink with</p>				<p>the policy of Riverbend Health Care Center to comply with regulatory requirement food procurement store, prepare and serve sanitary1. Upon notification from the surveyor facility contacted ECOLAB to service the dish washing machine. The facility staff #2 stopped using machine and awaited ECOLAB service technician evaluation of machine. Ecolab service completed and facility order new squeeze tubes and installed on 11/21/11 and issue was resolved.Dietary manager completed re-education with dietary staff #2 on the proper procedure for 3-compartment sink once notified by surveyor.2. ECOLAB completed dish machine service on 10/21/11 to ensure proper functioning.3. Dietary staff re-educated on 3 compartment sink, dish machine sanitation and chemicals.Dietary Manager or designee will QA dish machine daily x 7 days then weekly x 4 then monthly to ensure dish machine chemicals are dispensing properly.Dietary Manager will conduct QA return demonstration x 2 months of dietary staff to ensure they are following policy related to the 3-compartment sink.Dietary staff re-educated on the proper handling of raw food and hand washing procedure per Dietary manager.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>clear water, and the third sink was empty with no drain stopper in sight. Dietary Staff #2 was observed washing pots and pans without using the sanitizing rinse. When queried, the staff member indicated the pans she put away were washed earlier. She then proceeded to search the kitchen for a sink stopper. Once a stopper was found, she then filled the sink with the sanitizer solution and the levels tested were within normal limits. Dietary Staff #2 then proceeded to wash additional pans and a cookie sheet in the sink dipping the dishes in the sanitizer briefly (couple of seconds) before putting the items on the rack for drying.</p> <p>On 10/17/11 at 10:00 a.m., the sanitizing solution had drained from the three compartment sink. The Dietary Manager went looking for another stopper for the sink before refilling with sanitizing solution.</p> <p>The Dietary Manager was interviewed on 10/17/11 at 10:07 a.m. During the interview, the Dietary Manager indicated the dishes should be submerged in the sanitizing solution for at least 15 seconds. He further indicated he wasn't sure why the dish machine's sanitizing solution was not working. He indicated the container</p>				Improvement (RMQI) committee for further review and recommendations, until 100% compliance is achieved times 3 months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>of solution was half full but was not getting into the dish machine.</p> <p>The current policy and procedure for Cleaning &amp; Sanitizing, dated 6/09, was provided by the Dietary Manager on 10/24/11 at 8:15 a.m. The policy indicated "...Temperatures and chemical strength will be checked at each meal and recorded on the Dish Machine/Sanitizer Log...fill three (3) compartment sink...wash pots, pans, and utensils in hot soapy water...rinse in clear water...put in sanitizing sink for at least one (1) minute...."</p> <p>The Dietary Manager provided a copy of the sanitizing solution manufacture instructions on 10/24/11 at 8:43 a.m. The undated product specification document indicated "expose all surfaces to the sanitizing solution for a period of not less than 1 minute...."</p> <p>2. On 10/17/11 at 10:00 a.m., Dietary Staff #2 was observed removing the lid from the trash can and throw something away before replacing the lid back on the can. After this, the staff member proceeded to obtain a clean coffee filter and make a pot of coffee without washing hands first.</p> <p>On 10/17/11 at 10:02 a.m., Dietary</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Staff #2 was observed chopping up raw bananas using his bare hands to hold the banana on the cutting board. After the bananas were cut into chunks, the staff member picked up the banana pieces with bare hands and placed in a container.</p> <p>On 10/17/11 at 10:12 a.m., Dietary Staff #2 washed hands and turned off the water with bare hands before drying hands with a paper towel. The staff member then proceeded to get a can of fruit cocktail, open it without cleaning the lid, and proceeded to pour the fruit cocktail in with the bananas that had been cut up a few minutes earlier. Next the Dietary Staff lifted the trash lid with bare hands to throw away the can. The staff member did not wash hands before proceeding to gather a spoon and stir the fruit cocktail.</p> <p>On 10/24/11 at 8:15 a.m., the Dietary Manager provided the current policy and procedure for Handwashing, dated 2/09. The policy included, but was not limited to: hands must be washed after contact with contaminated items or surfaces, turn on water, wash hands thoroughly, rinse hands, dry hands with paper towel, turn faucets off with the paper</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/24/2011
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0428 SS=D	<p>towel.</p> <p>3.1-21(i)(2)</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure Pharmacy Consultant Reports were acted upon by the physician for 2 of 10 residents (Resident #37 and Resident #10 reviewed for medications.</p> <p>Findings include:</p> <p>1. Resident #37's record was reviewed on 10/17/11 at 2:30 p.m. The record indicated Resident #37's diagnoses included, but were not limited to, congestive heart failure, coronary artery disease, depression, dementia, and osteoarthritis.</p> <p>An Admission Order Plan of Care for Resident #37, dated 8/6/10, indicated the resident was receiving celexa (antidepressant) 20 mg every day.</p>	F0428	<p>F 428 SS:D Drug Regimen review It is the policy of Riverbend Health Care Center to comply with regulatory requirement Drug regimen review, report, irregular, act on.1. Res #37 re-assessed by physician and a gradual dose reduction has been acted on Res # 10 re-assessed by physician and documentation on GDR has been completed2. Facility had reviewed pharmacy GDR recommendation, past 60 days, to ensure physician has documented rational as to why reduction not attempted.3. Administrator to re-educate facility physician on regulation 329 and GDR documentation.IDT will review GDR in monthly care review meeting to ensure documentation reflects rational as to why reduction not attempted or recommendation not accepted by</p>	11/23/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>A Pharmacy Consultant Report, dated 11/11/10, indicated Resident #37 "has taken citalopram (celexa) 20 mg QD (every day) for management of major depressive disorder since 8/09...please consider documenting that gradual dose reduction (GDR) is clinically contraindicated...." The physician signed the report December 2010 declining the recommendation for GDR but did not document rationale.</p> <p>A Pharmacy Consultant Report, dated 09/28/11, indicated "Repeated recommendation from 6/20/11" for GDR of citalopram. The report indicated Resident #37 was receiving citalopram 20 mg every day since 8/09. The report was not signed until 10/7/11 confirming a GDR is appropriate.</p> <p>The Director of Nursing (DON) was interviewed on 10/24/11 at 8:15 a.m. During the interview, the DON indicated the facility does not have a policy and procedure for Pharmacy Consultant Reports. She indicated the reports are given to the physician for signature or follow-up.</p> <p>2. Resident #10's record was</p>			<p>MD.Social Service or designee will QA monthly pharmacy GDR recommendations for appropriate documentation by physician includes rational as to why reduction not attempted.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality Improvement (RMQI) committee for further review and recommendations as indicated.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>reviewed on 10/17/11 at 3:00 p.m. The record indicated Resident #10's diagnoses included, but were not limited to, depression, fibromyalgia, and multiple sclerosis.</p> <p>A Pharmacy Consultant Report, dated 4/18/11, indicated "has taken cymbalta 60 mg every day since 3/15/09 for management of depressive symptoms...please consider a gradual dose reduction...." There was no documentation by the physician on the form indicating why a GDR was not to be attempted.</p> <p>A Pharmacy Consultant Report, dated 10/19/10, indicated "has taken cymbalta 60 mg every day since 3/15/09 for management of depressive symptoms...please consider a gradual dose reduction...." There was no documentation by the physician on the form indicating why a GDR was not to be attempted.</p> <p>3.1-25(h)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to ensure accurate documentation for the use of a hand splint for 1 resident (Resident #5) and accurate documentation for dycem in a wheelchair for 1 resident (Resident # 37) of 36 residents reviewed in Stage 2.</p> <p>Findings include:</p> <p>1. Review of the clinical record for resident #5 on 10/19/11 at 9:30 a.m. indicated the resident was admitted to the facility on 6/28/11 with diagnoses including but not limited to Hemiplegia left side, Diabetes, Neuropathy and Hypertension. Review of the Admission Minimum Data Set (MDS) dated 7/6/11 indicated the resident had functional limitation on one side of the upper and lower extremity.</p>			F0514	<p>F 514 SS: D Records-complete/accurate/accessibleIt is the policy of Riverbend Health Care Center to comply with regulatory requirement resident records complete, accurate and accessible.1. Res #37's Care Plan revised to include the intervention of dycum (non-slip material). Res #5 is currently on therapy caseload for evaluation and treatment for splint application per MD order.2. The facility has reviewed documentationlast 30 days for inaccuracy and omissions.3. Licensed staff re-educated on facility policy and procedure related to complete and accurate documentation.DON or designee will QA in daily clinical meeting documentation of licensed staff for completeness and accuracy. Corrective education will be completed as indicated.4. Results from QA reviews will be forwarded to the Facility Risk Management Quality</p>		11/23/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Observation of the resident on 10/17/11 at 11:30 a.m. indicated the resident was in her wheelchair and her left arm was noted to be bent towards her left shoulder. Her left hand was noted to be contracted. Interview with the resident on 10/17/11 at 11:45 a.m. indicated she had lived at a different facility and had a hand splint but has not seen it since coming to the new facility.</p> <p>On 10/18/11 at 9:30 a.m. review of the resident's admission orders dated 6/28/11 indicated the resident was to wear a left hand splint during the day up to 6 hours and replace with a therapy carot throughout the night as tolerated. Also an order to check skin before and after splint applied to left hand/arm wash and dry areas well before and after splint application.</p> <p>Interview with nurse # 6 on 10/18/11 at 11:00 a.m. indicated she did not know the resident was to have a hand/arm splint. Observation of the resident on 10/18/11 at 3:00 p.m. the resident was observed to have a hand/arm splint. Interview with the resident indicated staff had found the splint in her closet. .</p> <p>On 10/20/11 at 2:20 p.m. interview</p>				Improvement (RMQI) committee for further review and recommendations, until 100% compliance is achieved times 3 months.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>with CNA # 4 and #7 indicated they had never seen the resident wear a hand brace.</p> <p>On 10/20/11 at 2:30 p.m. review of the October 2011 "Treat Administration Record" for the resident indicated nursing staff were signing every shift that the resident was wearing a hand splint and her skin was being checked before and after the application of the splint.</p> <p>2. On 10/20/11 at 3:02 p.m., Resident #37 was observed in her room, no dycem was noted in the wheelchair.</p> <p>On 10/24/11 at 9:10 a.m., Resident #37 was observed in bed. The resident's wheelchair was sitting beside the bed with a pressure reducing cushion in the seat along with the hoyer sling pad. No dycem was observed.</p> <p>A telephone order, dated 1/15/11, indicated dycem was to be placed on Resident #37's wheelchair seat.</p> <p>Nurse's Notes, dated 1/15/11 at 11:30 a.m., indicated Resident #37 was assisted to the floor after the resident slid from her wheelchair. The note</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2011	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN46819			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>further indicated the resident's hoyer pad was removed and dycem was placed in the chair.</p> <p>CNA #4 was interviewed on 10/24/11 at 9:10 a.m. During the interview, CNA #4 indicated Resident #37 used to use dycem (non-slip material) but not anymore. She further indicated none was in the wheelchair currently, just a cushion.</p> <p>The October 2011 Medication Record for Resident #37 listed "dycem to w/c [wheelchair] seat - check placement every shift. The sheet was signed by nursing that the dycem was checked and in place every shift.</p> <p>3.1-50(a)(2)</p>						